**CITY OF MINNEAPOLIS**

# CERTIFICATION OF HEALTH CARE PROVIDER

## **Employee's** Serious Health Condition

**(Family and Medical Leave Act)**

**Employee ID:**

| **Leave Start Date**: | **Leave End Date**: |
|---|---|

## SECTION I: For Completion by the Department's HR Consultant

**TO BE COMPLETED BY THE HR/FMLA Consultant** and returned to employee. Employee should submit completed form back to their HR/FMLA Consultant. Please type or print in ink. (If additional space is needed, add additional sheets.

| **HR Consultant:** | **Phone:**<br>**Fax:**<br>**Email Address:** |
|---|---|
| **Employee's Essential Job Functions:**<br><br>**Check if job description is attached:** [ ] | |

## SECTION II: For Completion by the EMPLOYEE

**TO BE COMPLETED BY THE EMPLOYEE:** Please complete Section II before giving this form to your medical provider.

| **Employee's Name (First, Middle, Last)** | | **Phone:** |
|---|---|---|
| **What will your pay status be during this leave of absence? (Select all that apply)**<br>☐ **Sick** ☐ **Unpaid**<br>☐ **Vacation** ☐ **Compensatory Time**<br>☐ **Workers Comp**<br>**Explain or list options:** | | **Do you plan to take this leave intermittently?**<br>☐ **Yes**<br>☐ **No** |
| **Name of Supervisor:** | | **Department:** |
| **Employee's Job Title:** | | **Phone:** |
| **Data Privacy Notice**: Some of the information you or your health care provider will supply on this form is private data under the Minnesota Government Data Practices Act, Minn. Stat. ch. 13. The purpose of collecting such private data is to determine whether you are entitled to leave under the Family and Medical Leave Act. You are not required to provide the information on this form. However, if you do not complete this form, you might not be eligible for FMLA leave. Information on this form may be available to City employees or agents, labor union representatives, a City-sponsored health care provider, labor union representatives, arbitrators and administrative hearing examiners, State and Federal courts, and attorneys representing any of the mentioned individuals or entities, and to others through subpoena or pursuant to Federal or State law. | | **Regular Work Schedule:** |
| **Employee Signature:** | **Date:** | **Phone Number:** |

## SECTION III: For Completion by the HEALTH CARE PROVIDER

**INSTRUCTIONS to the HEALTH CARE PROVIDER:** Your patient has requested leave under the FMLA. Answer, fully and completely, all applicable parts below. Several questions seek a response as to the frequency or duration of a condition, treatment, etc. Your answer should be your best estimate based upon your medical knowledge, experience, and examination of the patient. **Be as specific as you can; terms such as "lifetime," "unknown," or "indeterminate" may not be sufficient to determine FMLA coverage.** Limit your responses to the condition for which the employee is seeking leave. **Please complete and mark items below as applicable. Please be sure to sign the form on the last page.**

| **Name of Health Care Provider:** | **Type of Practice / Medical Specialty:** |
|---|---|
| **Name of Hospital or Clinic and Business Address:** | **Phone:** **Fax:**<br><br>**Email Address:** |

The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits employers and other entities covered by GINA Title II from requesting or requiring genetic information of an individual or family member of the individual, except as specifically allowed by this law. To comply with this law, we are asking that you not provide any genetic information when responding to this request for medical information. 'Genetic Information' as defined by GINA, included an individual's family medical history, the results of an individual's or family member's genetic tests, the fact that an individual or an individual's family member sought or received genetic services, and genetic information of a fetus carried by an individual or an individual's family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services." (29 C.F.R 1635.8(b)(1)(i)(B)

## PART A: MEDICAL FACTS

1. Approximate date condition commenced: _____ Probable duration of condition: _____

   a. Was the patient admitted for an overnight stay in a hospital, hospice, or residential medical care facility? Yes ☐ No ☐ If so, dates of admission: _____
   b. Date(s) you treated the patient for condition: _____
   c. Will the patient need to have treatment visits at least twice per year due to the condition? Yes ☐ No ☐
   d. Was medication, other than over-the-counter medication, prescribed? Yes ☐ No ☐
   e. Was the patient referred to other health care provider(s) for evaluation or treatment (e.g., physical therapist)? Yes ☐ No ☐
      If so, state the nature of such treatments and expected duration of treatment: _____
      _____

2. Is the medical condition a pregnancy? Yes ☐ No ☐ If so, expected delivery date: _____

3. Use the information provided by the employer in Section I to answer this question. If the employer fails to provide a list of the employee's essential functions or a job description, answer these questions based upon the employee's own description of his/her job functions:

   a. Is the employee unable to perform any of his/her job functions due to the condition? Yes ☐ No ☐
   b. If so, identify the job functions the employee is unable to perform: _____
      _____
      _____

4. Describe other relevant medical facts, if any, related to the condition for which the employee seeks leave (such medical facts may include symptoms, diagnosis, or any regimen of continuing treatment such as the use of specialized equipment):
   _____
   _____
   _____

## PART B: AMOUNT OF LEAVE NEEDED

5. Will the employee be incapacitated for a single continuous period of time due to his/her medical condition, including any time for treatment and recovery? Yes ☐ No ☐ If so, estimate the beginning and ending dates for the period of incapacity:

   **Beginning:** _____ **Ending:** _____

6. Will the employee need to attend follow-up treatment appointments, or work part-time, or on a reduced schedule because of the employee's medical condition? Yes ☐ No ☐

   a. If so, are the treatments, or the reduced number of hours of work, medically necessary? Yes ☐ No ☐
   b. Estimate treatment schedule, if any:

      1. Dates of any scheduled appointments: _____
      2. Time required for each appointment, including any recovery period: _____
         _____

   c. Estimate the part-time or reduced work schedule the employee needs, if any: _____ hour(s) per day; _____ days per week from _____ through _____

7. Will the condition cause episodic flare-ups, periodically preventing the employee from performing his/her job functions? Yes ☐ No ☐

   a. Is it medically necessary for the employee to be absent from work during the flare-ups? Yes ☐ No ☐ If so, explain:
      _____

   b. Based upon the patient's medical history and your knowledge of the medical condition, estimate the <u>frequency of flare-ups</u> and the <u>duration of related incapacity</u> that the patient may have over the next 6 months (e.g., 1 episode every 3 months lasting 1-2 days):

   Frequency: _____ times per _____ week(s) _____ month(s)
   Duration: _____ hours or _____ day(s) per episode

**ADDITIONAL INFORMATION**: Identify the question number with your additional answer(s):
_____
_____
_____
_____

| **Signature of Health Care Provider:** | **Date:** |
|---|---|
| | |

# FMLA Definition of Serious Health Conditions

**Based on guidelines from the U.S. Department of Labor**

| TYPE | QUALIFYING CRITERIA | EXAMPLES |
|---|---|---|
| **1.** Hospitalization and Subsequent Treatment | INCAPACITY* INVOLVING AN OVERNIGHT STAY IN A HOSPITAL OR RESIDENTIAL MEDICAL CARE FACILITY | Hospitalization for surgery<br>Post-surgery doctor's exam<br>Post-surgery physical therapy sessions |
| **2.** Pregnancy and Prenatal Care | ANY PERIOD OF INCAPACITY*<br>No other qualifications<br>A doctor's visit during the absence is *not* required.<br>The employee husband of a pregnant spouse is entitled to FMLA leave to care for the pregnant spouse. | Morning sickness<br>Doctor's visit for prenatal care |
| **3.** Chronic Conditions | ANY PERIOD OF INCAPACITY* due to a chronic condition which:<br><br>1. Requires visits for treatment by a health care provider at least twice a year<br><br>2. Continues over an extended period of time (including recurring episodes of a condition)<br><br>3. May cause episodic rather than continuous incapacity<br><br>A doctor's visit during each absence is *not* required. | Asthma, diabetes, epilepsy, migraine headaches |
| **4.** Conditions Requiring Multiple Treatments | ANY PERIOD OF INCAPACITY* for restorative surgery or for conditions that if left untreated would result in incapacity of more than 3 consecutive calendar days. | Chemotherapy or radiation for cancer<br>Dialysis for kidney disease<br>Physical therapy for arthritis |
| **5.** Permanent/Long Term Conditions | ANY PERIOD OF INCAPACITY*.<br>Individual must be under the continuing supervision of, but need not be receiving active treatment by, a health care provider. | Alzheimer's, stroke, terminal diseases |
| **6.** Other Health Conditions | INCAPACITY* MUST BE FOR MORE THAN 3 CONSECUTIVE CALENDAR DAYS **AND**<br>1. Involves treatment 2 or more times by a health care provider and the 2 visits must occur within 30 days of the period of incapacity. The first visit must occur within 7 days of onset of incapacity.<br>***OR***<br>2. Involves treatment 1 time by a health care provider followed by a continuing regimen of treatment. | (Not *normally* included: common cold, flu, earache, routine dental problems)<br>Physical therapy sessions ordered by a doctor for a broken leg<br>A visit to doctor followed by course of prescription antibiotics |

*** Incapacity** – Inability to work, attend school or perform other regular daily activities due to the serious health condition, treatment therefore, or recovery there from.